COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Advisory Committee Minutes

Holiday Inn-North
2805 Highwoods Blvd., Raleigh, N.C. 27604

Wednesday, April 12, 2006

Attending:
Advisory Committee Members: Marvin Swartz, MD, Laura Coker, Clayton Cone, Dorothy Crawford, Ann Forbes, Mary Kelly, Judy Lewis, Martha Macon, Emily Moore, Carl Shantzis, Ed.D., CSAPC, Don Stedman, Ph.D., Fredrica Stell,

Ex-Officio Committee Members: Bob Hedrick,

Excused: None

Division Staff: Steven Hairston, Denise Baker, Markita Keaton, Leesa Galloway, Shelia Bazemore, Chris Phillips, Pheon Beal, Felissa Ferrell, Ann Remington

Others: John Owens, Jere Annis, Cynthia Wiford, John Tote, Doug Dixon, Holly Riddle, Michael Mayer, Karen Stallings, Phyllis Gurley, Carol Matthieu

Handouts:
Mailed Packet:
January 18, 2006 Advisory Committee Agenda
Workforce Development Plan 2004
CFAC information packet
A History of the Effort to Develop North Carolina's Consumer Affairs Function by Joe Donovan
Handouts:
MH/DD/SAS Proposed Workforce Taskforce
The Annapolis Coalition on the Behavioral Health Workforce: Building a National Strategic Plan for Behavioral Health Workforce Development
National Council for Community Behavioral Healthcare, March/April 2006

Call to Order:
Chairman, Marvin Swartz opened the meeting at 9:40 a.m.
Mr. Swartz asked the Commission members, Ex-Officio Committee Members, Division Staff and visitors to introduce themselves.

Approval of Minutes:

Upon motion, second and unanimous vote, the Advisory Committee approved the minutes of the January 18, 2006 Advisory Committee meeting.

Workforce Development:
Dr. Swartz gave a summary of how to approach handling the Workforce sub committees in order to achieve the goals of each committee. Dr. Swartz suggested inviting trainers or other individuals in the workforce development business to each session to give advice regarding what is available and who is available for workforce development. Their attendance will help the advisory committee understand what the state's capacity is now and how that translates into the future needs.

The first workgroup will be the Governance committee - this subcommittee would have responsibility for researching and defining systems functions and policy clarity between the Division, LMEs, providers and stake holders.

This workgroup will identify what functions each agency is supposed to handle, including: the role of the Division, LME, and private providers; who pays for what services; what are and where are the available dollars, and where should those dollars be? Don Stedman will chair the Governance committee with team members Carol Duncan Clayton, Mike Mayer, Dave Richards and John Owen.

The next subcommittee is the Workforce Data and Information workgroup which will have responsibility for providing analysis of labor market information and statistical data related to the present and future workforce of North Carolina as it relates to MH/DD/SA services. Clayton Cone will chair this committee. Carl Shantzis will serve on this team.

The last subcommittee is the Professional and Staff Workforce Development workgroup, which will consist of the Advisory Committee as a whole. It will examine all aspects of the provision of care across all disability categories. This workgroup will work with the Council on Developmental Disabilities (DD) on matters related to the direct care workers for the DD populations. However, the effort will include the provision of all professional and direct care staff. This workgroup will be dually chaired by Marvin Swartz and Steven Hairston with team members Holly Riddle and Cynthia Wiford.

Upon motion, second and unanimous vote the Advisory Committee approved the Mental Health, Developmental Disabilities and Substance Abuse Services Proposed Workforce Taskforce plan.

Marvin asked Don Stedman to propose a timeline based on his experience with the Housing taskforce. Dr. Stedman stated due to the importance of workforce development and its complexity the earliest time for the Advisory Committee to submit a detailed report to the Commission is the fall of 2007 (1 ½ years). John Tote suggested initiating a more aggressive beginning to Don's proposed timeline because the lack of workforce is placing a burden upon providers particularly in the areas of training and documentation. Mr. Tote opined that smaller providers will be obsolete by this time next year if the Division doesn't offer them a solution in the short-term. Steven Hairston stated that there was some discussions of building interim reports into the process in an effort to address the immediate needs of the system with the long term needs being addressed in the workgroups and included in the final report.

Holly Riddle stated that the Council on Developmental Disabilities is prepared to offer Dr. Amy Hewitt's expertise for the next nine months to assist with research on professional and direct care staff.

Judy Lewis stated that providers are having difficulty getting training for their staff particularly when a training session can only train 20 people at one time. She added that this is causing a big strain on providers trying to keep up with the required standards.

Mike Mayer stated that the Legislative Oversight Committee is looking for the Commission for MH/DD/SAS to provide clear guidance on what to fund. The Division has acute issues that require short-term remediation while developing the long-term study. Mr. Mayer recommends that there be an interim report as an immediate response to keep the workforce development system from imploding.

John Owens stated that an example of an urgent problem is the new Service Definition that ACTT teams require a peer support specialist. This is a problem because the training has not been developed. He suggested that someone from the community colleges be a member of one of the workforce workgroups because if they recognized need/market for the training community colleges would take responsibility for making sure training was available.

Marvin Swartz indicated that at the first meeting regarding workforce development it was decided that individuals representing the community college, university system and other training entities will be involved in this process. Dr. Swartz stated there seems to be an urgency to create interim reports and submit a report prior to the short session. Senator Nesbitt was described as trying to obtain a minimum of $100m for Mental Health. The N.C. Psychiatric Associations' report card based on data obtained from the National Association of State Mental Health Program Directors stated that NC is 43 out of 50 in funding and that there isn't a budget to drive training initiatives like person centered planning.

Jere Annis suggested that the Advisory Committee may be able to effectively separate what needs to be addressed into two problems. 1) Creating a system with the Division and LME to provide support to providers in the short-term, while 2) working on long-term recommendations. In essence the Division will establish a mechanism (i.e., emergency support) to keep providers a float until the long-term study is completed.

Steven Hairston agreed stating that a fundamental position the Advisory Committee will have to decide upon is the policy on how to submit recommendations for and identify the issues that are immediate and/or long-term. He suggested allowing the Advisory Committee as the whole to address the short-term needs called "immediate" and the workgroups to work on the long-term needs.

Dorothy Crawford stated that the financial need should be addressed for each issue.

Emily Moore stated that the General Assembly will return in May and if something is not submitted an entire year will be missed.

Laura Coker stated that at the Provider's summit training issues were not discussed in detail and questioned if a training summit could be developed prior to the short session to identify needs and submit a recommendation. The LMEs had a specific directive to assist and support the training and development needs of the providers. The figures published in the psychiatric association's bulletin revealed how under funded the state level is but it did not address the money committed to the LME infrastructure. Some LMEs have managed their funds better than others and financial management is an important piece for the long-term study.

Don Stedman stated that there has to be an immediate reaction to raise awareness; however, the committee should be cautious about taking on a responsibility without any follow through. The "easiest" part is to create training programs and submit the logistics and lobby for money. There are two other pieces: 1) a cultural problem with people being demoralized because there isn't a career path; and 2) there is a disconnect between the systems in the state on the issue. If these types of issues are not resolved they will be issues the committee will have to address each year.

Marvin Swartz stated that one potential short-term objective is to draft a resolution indicating the need for additional funding, establish a monetary amount for workforce develop, and support Senator Nesbitt's initiatives. Dr. Swartz proposed submitting the draft resolution to the Commission for endorsement at the meeting on May 18. 2006.

Mike Mayer stated that the Chair of the Workforce Competency Committee under Rich Visingardi's leadership was to identify the available funds that were within in the system for training for the direct, associate, and qualified professional levels. The Workforce Competency Committee concluded that there were only two extremely small funding steams for this type of training. In the CAP services only 2.5% of funding was allocated for the training for the staff implementing the services and to the LME for training and technical assistance. When dollar value was compared against the estimated total cost of providing the needed training the total

was 1.4% of the total mean was designated for training within the system at the time. The Commission passed the rule that stated "at such time" to develop a competency based workforce but when the fiscal note was for 5 million dollars the project fell through. Dr. Stedman added that that amount did not include funding for pre-professionals; it was only for service systems training needs.

Marvin Swartz stated that he would draft a resolution that will be circulated via email for submission to the Commission.

Laurie Coker asked if figures could be obtained from some of the national behavioral or healthcare agencies. Holly Riddle stated that the Council on Developmental Disabilities has been working on the direct support professional issue in 1999; therefore, the council has figures and information pertaining to direct support staff available from 1999.

Steven Hairston proposed submitting a dollar figure that the Advisory Committee would be willing to defend. Dr. Swartz proposed framing the figures to coincide with the figure being proposed for Mental Health by Senator Nesbitt.

Carl Shantzis offered support of the long-term report with interim reports indicating that the important need is to obtain a snap shot of the current status that will confirm the Advisory Committee's position. Gathering the workforce data information would include: 1) gathering the information 2) determining the current status, 3) identifying the anticipated growth or need based on the assumption the Division is not where it needs to be, and 4) identifying the Division's readiness to meet those needs. This information will allow dollars to be assigned and help make recommendations. Mr. Shantzis asked if there were snap shot reports that could be generated by the LME across all disabilities that will help the Advisory Committee gather the information to identify the need.

Holly Riddle suggested looking at the Advisory Committees workforce workgroup structure. Ms. Riddle suggested assigning Division staff, Dr. Hewitt and research staff that can compile the information needed relatively quickly. The Divisions workforce issues are distinctive enough to divide them across the disabilities.

Steve Hairston indicated that a Division staff person from the Operations Support Section will assist each workforce development workgroup throughout this process. The goal is to utilize Division staff and staff from the Labor Market Information Division at the Employment Security Commission to undertake the major research. At this meeting the goal is to obtain a timeline for collecting the staff and data together. A preliminary timeline would be to submit the resolution at the May Commission meeting and by July 12 bring all the information gathered at that time. The workgroups must drive these initiatives. The workgroups can not rely on the administrative staff to develop the policies and get the work done.

Dr. Stedman stated that the most urgent need is focusing on direct care issue and the Advisory Committee should not underestimate the enormity of this study and should be careful about raising additional concerns that will detract the committee's focus from the all issues. There will come a point in the study where the committee will need to hold counsel with the governor or secretary to see if this is an issue on their agenda and seek additional public or private professional resources.

Judy Lewis inquired if there would be a budget for this study similar to the Housing Taskforce Initiative. Holly Riddle stated that the Council on DD will be able to generate a portion of Dr. Hewitt's consultative capacities that can be extended to the end of September and with support from the Advisory Committee funding can be renegotiated. Dr. Stedman stated that the committee did have a budget for the Housing Taskforce Initiative but the committee will have to

get people mobilized around this issue; this could include, for example, businessmen advocating that their employees are losing job time because their family members aren't getting the services that they need and it is hurting my business.

John Owens stated that timelines have to be tied to the legislative schedule in order to make the appropriate funding requests. Also, the state has the resources to solve the issues facing the Division but they must be willing to communicate with the university, community college and other systems instead of contracting with consultants.

Marvin Swartz stated he will circulate a draft resolution for submission to the Commission for endorsement at the meeting on May 18. 2006. Dr. Swartz also suggested that the Commission is capable of fundraising through foundations that would support coalitions and there could be advantages to raising our own funds.

Steven Hairston stated that Pheon Beal, the lead person for the Secretary on workforce development is going to join the committee as a whole as a liaison to the Department's initiatives.

Chairman Marvin Swartz discussed the MH/DD/SA Workforce Needs that were presented to the House Select Health Committee on Workforce, February 23, 2006 by Carol D. Clayton, Ph.D. The NC Council of Community Programs (NCCP) is a 501(c)(3) organization that exists to serve and support the local public mental health, developmental disabilities, and substance abuse service system and its governance authorities. The mission of the NCCP is to improve and expand North Carolina's MH/DD/SA services through the collective voice of the Area Authority/County programs in the development and delivery of a cohesive system of care. NCCP has estimated that 1.1 million North Carolinians served in the public sector have no insurance. The range of services and supports required to address needs are psychiatric, medical support and Clinical Services (i.e. Licensed Qualified Psychologist, Clinical Nurse Specialist, Social Workers, LPC, etc.). Psychiatrist distribution data shows that there is an uneven distribution of psychiatrist across NC, potential shortage due to a growing population, critical shortage of child psychiatrist (43 counties do not have child psychiatrist, and a loss of psychiatric workforce in rural areas.

NCCP recommended the following:

1. Incentive plans to improve the supply and distribution of psychiatrist
2. Charging DHHS with finding a mechanism to address the shortage of psychiatrist including payment methods and rates
3. Increase General Assembly's support for AHECs so that targeted recruitment and placement of residents in underserved areas can occur and be supported through strengthened ties to the affiliated medical centers and network of colleagues
4. Analyze workforce statistics for Direct Support Professionals as a Part of the Economic Development Work of the General Assembly
5. Consider recruitment and retention supports for Direct Support Professionals similar to those applied to nursing
6. Study the actions taken by Congress and the Bush Administration to see what advantages NC can gain
7. Start a workforce collaborative to encourage a tuition payback program for clinical professionals to incentivize entry in to the MH/DD/SA workforce similar to the child welfare system workforce collaborative

Karen Stallings, Associate Director, discussed the North Carolina Area Health Education Centers (AHEC) Program: Mental Health Initiatives The mission of the North Carolina AHEC Program is to meet the state's health and health workforce needs by providing educational programs in partnership with academic institutions, health care agencies, and other organizations committed to improving the health of the people of North Carolina. AHEC educational programs and information services are targeted toward:

- Improving the distribution and retention of healthcare providers, with a special emphasis on primary care and prevention.
- Improving the diversity and cultural competence of the health care workforce in all health disciplines.
- Enhancing the quality of care and improving healthcare outcomes.
- Addressing the healthcare needs of underserved

Major AHEC program activities are as follows:
- Community-Based Student Experiences
- Primary Care Residency Training
- Support for Practicing Health Professionals
- Health Careers and Workforce Diversity
- Special Initiatives to Address Emerging Needs

The Goal of the Mental Health Workforce is to supply NC with psychiatrists and other mental health providers who are experienced with and committed to diverse and underserved populations who utilize the public mental health system.

New efforts for the AHECs include obtaining Psychiatric Nurse Practitioners. The AHECs Continuing Education Programs include, over 500 Mental Health Programs offered each year in the via workshops, on-line Behavioral Health Courses, Teleconferenced programs and Educational consultation and technical assistance. AHECs also collaborate with NC Division of MH/DD/SAS, NC Universities, community and state agencies, NC Council of Community Mental Health Programs, and Bureau of Health Professions – HRSA.

AHECs special initiatives are the NC AHEC Latino Health Resource Center, School Mental Health Project, NC Evidence Based Practices Center, Disaster Preparedness, Leadership and Management Training, MH and Primary Care Integration, and Cultural Competence.

AHECs also offer workforce Diversity Programs in Spanish Language Training for Health Practitioners for the front line caregivers, primary care practitioners and mental health, substance abuse professionals, Instructor Training, and Interpreter Training.

The Role of the Consumer and Family Advisory Committees (CFACs)
Chris Phillips, Chief, DMH/DD/SAS Advocacy and Customer Services, presented the role of the CFACs to the Advisory Committee. He informed the committee of how the CFACs were developed and implemented with State plans 2001, 2002, and 2003. Mr. Phillips provided a copy of the directive "Distinction Between Consumer and Family Advisory Committees and Human Rights Committees" from September 2, 2003 to each Committee member. The memo addressed questions that the Advocacy and Customer Services section were receiving. Mr. Phillips discussed a second directive, dated November 28, 2005, "Consumer/Family involvement in Monitoring Activities." This directive informed the Area Programs (AP)/Local Management Entity (LME) that "…active participation of consumers and family members in these activities can be immensely beneficial….Considering the amount of work and attention that this broader policy role entails, it would be impractical and inappropriate for CFACs as a group to be used for actual on-site monitoring." Mr. Phillips provided examples of a CFAC application, CFAC bylaws and the Consumer Empowerment Team Field Offices map as of March 2006.

Felissa Ferrell of the Advocacy and Customer Services' Consumer Empowerment Team discussed some of the roles and functions of the Empowerment Team. Team members are responsible for LME catchment areas around the state and their role is to help consumers have a voice and not fall through the cracks in the systems. Team members attend CFAC meetings and answer questions, address committee

processes, and provide updates from the Division and Department. Team members also help the CFAC learn who the quality monitoring / management staffs are for the LME to help build upon the strengths of the community, the CFAC and work together.

Ann Remington stated all CFACs and school systems were given a workbook "Transition to Community Services for Children in the Schools" located on the Division's website at http://www.dhhs.state.nc.us/mhddsas/childandfamily/pdf/mh-dpiworkbook2-8-06b.pdf.

Laura Coker stated that figuring out the scope of what CFACS were supposed to do has been difficult and a staff liaison is still available but the direct relationship between the board of directors and the CFAC has difficult to obtain.

Carol Matthieu stated the development of the CFACs is a step in the right direction for North Carolina and the country as well. Ms. Matthieu discussed the following challenges faced by CFACs with the Advisory Committee.

1. The LMEs need clearer guidance on their roles and functions in regards to the CFACs. The quality of the CFAC will be a reflection of the management style of the LME.
2. Getting consumer representation from substance abuse (SA), child mental health (Child MH) and child substance abuse (Child SA) has been a challenge because parents are dealing with issues that monopolize their time and are unable to participate in advocacy work.
3. LMEs with large catchment areas present difficulty with transportation and/or excessive travel.
4. Some CFACs are LME driven and do not take on challenges as a group, which is an example of CFACs need for more guidance on their roles, functions and authority.
5. There should be public notices and ads in the paper. Many consumers are still not aware that CFACs exist.
6. A stigma remains as a barrier in recruitment efforts because many people do not want others to know that they are dealing with a disability, therefore recruiting new members has been a challenge and many more issues.

Ms. Matthieu also presented recommendation from various CFAC members including:

1. Is there a way to require that the CFAC have a more meaningful role within the LME?
2. Develop a better outline for LME roles and functions and clearer guidance on how to support CFACs.
3. The LME should gather information on all committees and workgroups and decrease the number of these committees and workgroups based on overlapping functions or tasks.
4. The LME should staff the CFAC it should not be the LME director; rather, someone who understands the role of the CFAC, help CFACs organize and mange the work produced, communicate energy, enthusiasm, believe in the CFAC members and have a "Can Do" attitude about the CFAC and the work being produced.

5. Developing concise guidelines on who can be on the CFAC to avoid conflicts of interest.
6. The initial document presented to the CFACs should be revisited and studied for updates.
7. Make CFAC information available and current on the county websites and provide assistance with navigation of the Division's and other state websites.
8. CFACs members should visit other CFAC meetings to generate ideas
9. Educate local government staff and other elected officials about the CFAC where MH services have operated in isolation relative to other areas of government.

Marvin Swartz stated and Ms. Matthieu agreed that there should have a Question and Answer or an Executive Summary attached to communications to help explain the jargon used and the overall meaning of the communication in laymen's terms. Dr. Swartz also suggested allowing the State CFAC to review the communications for the local CFACs and offer suggestions on language to use for everyone to understand. Laurie Coker agreed and said that Customer Services Team should provide the summaries online also because the information is not only for CFAC but other consumers and families that are not apart of the CFAC.

Phyllis Gurley read a letter to the Advisory Committee expressing the trials and successes her family experienced while caring for her son Bobby. She expressed her thankfulness to a state and nation that is aware of the needs of person with MH needs. Ms. Gurley stated she was a CFAC chair for Eastpointe and the Director asked Ms. Gurley to attend the LME director's meeting and she learned that the LMEs have more issues than dealing with her problems. The LME board asked that she attend a board meeting with a report of the CFAC meetings. Ms. Gurley stated that sometime parents and consumers are going to have to step back and differentiate from their wants and needs. Overall she is very grateful for the hard work the Division has done on behalf of consumers in North Carolina.

Chris Phillips stated that the Legislative Oversight Committee has in their legislative agenda to focus on consumer and family involvement and it could pursue Secretary Rule to fortify CFACs throughout the State. Dr. Swartz stated that upon the information Mr. Phillips receives the Advisory Committee is willing to recommend to the Commission that rules be developed for CFACs. Mr. Phillips stated from discussion with Secretary Odom she is in favor of solidifying the CFACs in rules. Dr. Swartz asked Mr. Phillips to provide an update at the next Advisory Committee meeting in July 2006

Laurie Coker asked Chris Phillips if the Relational Agreements usually have the roles and responsibilities of the Department of Health and Human Services (DHHS) identified and asked if Mr. Phillips saw a change in the relational agreements. Mr. Phillips stated that the local relational agreements have been included the Division in the dispute resolution process. The Division was signatory to the relation agreements but Mr. Phillips no longer has to sign the agreements on behalf of the Division because they will be determined locally.

Carl Shantzis suggested having a CFAC orientation that could be web-based or a web-cast such that anyone would be able to access the presentation. New CFAC members could use the website to identify their role and help get them started.

There was no public comment.

There being no further business the meeting adjourned at 3:30pm